DoD Medical Examination Review Board
8034 Edgerton Drive, Suite 132
USAF Academy, Colorado 80840-2200

INSOMNIA QUESTIONNAIRE

NAME: _____SOCIAL SECURITY NUMBER: _____-____-_____

Please complete the questions below regarding history of insomnia and return this form to DoDMERB at the above address: If more space is needed, please use back of form and identify each issue by question number.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397

PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corp (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applicants to their Academies.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

1) Have you been treated by a healthcare provider for sleep difficulties or insomnia? YES NO
If yes, please explain in as much detail as possible: _____
_____
_____
_____

2) Do you use any medications (including over-the-counter) to help you sleep? YES NO
If yes, what are the medications and how often do you use them?: _____
_____
_____
_____

3) Within the past year, have you had difficulty sleeping? YES NO
If yes, please explain in as much detail as possible): _____
_____
_____
_____

4) Certification: By signing below, I hereby certify that the above information is true and accurate to the best of my knowledge.

_____ _____
Applicant's Signature Date